UM-CDG-049 Headache and Occipital Neuralgia Treatments	Approved By: Director, Health Services	Effective Date: 10/22/2025

This Policy applies to all SECUR affiliates, associates, and subsidiaries.

Approved by Courtney Gonzales, Director of Health Services on behalf of the Utilization Management Committee.

PURPOSE

This coverage determination guideline serves to address headache and occipital neuralgia treatments. Chronic headache/occipital neuralgia can result from chronic spasm of the neck muscles because of either myofascial syndrome or underlying cervical spinal disease. It may be either unilateral or bilateral, constant, or intermittent. Nerve injury secondary to a blow to the back of the head or trauma to the nerve from a scalp laceration can also be a cause. Most commonly, an entrapment of the occipital nerve in its course from its origin from the second cervical (C2) nerve root to its entrance into the scalp through the mid portion of the superior nuchal line, is the cause. Numerous treatments have been proposed for headaches and occipital neuralgia including ablative techniques, injections/blocks, occipital nerve stimulation, peripherally implanted nerve stimulation, and surgical procedures.

For SECUR Health Plan members, National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) will be applied to requests when applicable. SECUR Health Plan Coverage Determination Guidelines (CDG) will be utilized in the absence of an appropriate NCD and/or LCD.

DEFINITIONS

Ablative Procedures: include ablation, radiofrequency ablation (RFA), RF denervation, RF neurotomy, cryodenervation (cryoablation/cryosurgery), neurolysis, and may be performed to denervate the occipital nerve, upper cervical nerve, supraorbital, supratrochlear, or sphenopalatine ganglion.
Injection Therapy: delivers local anesthetics, steroids, or other agents into the affected nerves.
Occipital Nerve Stimulation (ONS): electrical impulse is sent to the tissue around the occipital nerves and the electrical current blocks or disrupts the normal transmission of pain signals and creates a tingling sensation.
Peripherally Implanted Nerve Stimulation/Peripheral Nerve Stimulation (PNS): transmits electrical current via an electrode that has been implanted adjacent or parallel to the selected peripheral nerve.
Cefaly Supraorbital Transcutaneous Neurostimulator (Cefaly Enhanced): proposed as an alterative to medical treatment to prevent or treat episodic migraine in adults. This device is similar to a headband and sits across the forehead applying an electric current to stimulate branches of the trigeminal nerve. Cefaly Connected is Bluetooth enabled to be used with the CeCe Migraine Management app.
HeadaTerm 2: like the Cefaly devices, approved to both treat and prevent migraine by stimulating the supraorbital and supratrochlear nerves.
Nerivio: wireless, battery operated, noninvasive, wearable remote electrical stimulation/neuromodulation unit for the treatment of episodic or chronic migraine.
Nocira: designated by the US Food and Drug Administration (FDA) for the treatment of acute migraines in adults through controlled puffs of air unto the external ear canal to produce subtle pressure changes that are theorized to stimulate multiple nerves that target the brain's pain centers.

Relivion MG: FDA approved device that utilizes noninvasive neuromodulation technology to concurrently stimulate the two major nerve pathways that are believed to be responsible for migraines by targeting and activating the six branches of the occipital and trigeminal nerves.

POLICY

SECUR Health Plan will consider the following treatments for headache and/or occipital neuralgia as medically necessary when the following are met:

1. Botulinum toxins injection when the following are met:
   - Chronic daily headaches characterized by: headache occurring more than 15 days per month, duration of 4 or more hours per day, occurring for a period of three months or greater, and member has significant disability due to the headaches, and have been refractory to standard and usual conventional therapy.
   - Chronic migraine characterized by: headache on greater than 15 days per month and at least 8 headache days per month meet criteria for migraine without aura or respond to migraine specific treatment
   - For continuation of botulinum toxin therapy, the member must demonstrate a significant decrease in the number and frequency of headaches and an improvement in function upon receiving the botulinum toxin
   - Per Medicare, payment is allowed for one injection per site regardless of the number of injections made to the site. A site is defined as one side of the face or neck
2. Occipital nerve block to confirm diagnosis of occipital neuralgia.
3. Occipital nerve denervation for the diagnosis of occipital neuralgia, if only temporary relief of symptoms after an occipital block is obtained, neurolysis of the greater, lesser, and third occipital nerve may be considered via multiple techniques including radiofrequency and cryoanalgesia.
4. Occipital nerve stimulation when the following are met:
   - Documented chronic and severe pain for at least three months, and
   - Documented failure of less invasive modalities/medications, and
   - Lack of surgical contraindications including infections/medical risks, and
   - Appropriate member education, discussion, and disclosure of risks and benefits, and
   - No active substance abuse issues, and
   - Formal psychological screening by a mental health professional, and
   - Successful stimulation trial with greater than or equal to 50% reduction in pain intensity before permanent implantation

The following are considered not medically necessary:

1. Botulinum toxins following failure of two definitive, consecutive, treatment sessions involving a muscle or group of muscles could preclude further coverage of the serotype used in the treatment for a period of one year after the second session. It may be medically necessary to attempt with a different serotype.
2. Injections/blocks including but not limited to C2 ganglion nerve block and supratrochlear nerve block.
3. Surgical interventions including but not limited to the following:
   - Decompression of the supraorbital and supratrochlear nerves
   - Ganglionectomy
   - Microdecompression of the occipital nerve
   - Neuroplasty
   - Resection/partial resection of the semispinalis capitis muscle
   - Sensory nerve decompression

- Transection/avulsion of the occipital nerve
- Transposition of a cranial sensory nerve
- Vascular ligation of superficial extracranial arteries

Current medical literature shows there is no evidence to determine that these services are standard medical treatments.

4. Ablative techniques including neurolysis, pulsed radiofrequency ablation (RFA), and rhizotomy.
5. Cefaly Supraorbital Transcutaenous Neurostimulator, including Cefaly Connected and Enhanced.
6. Nerivio device
7. Nocira device
8. Noninvasive electoral stimulation of the supraorbital and/or supratrochlear nerves for either the prevention or treatment of headaches including but not limited to Cefaly devices, HeadaTerm 2 devices, and Relivion MG devices.
9. Occipital nerve stimulation via an implantable peripheral nerve stimulator for the following conditions:
   - Cluster headache
   - Neck pain
   - Tension headache
10. Sphenopalatine nerve block or sphenopalatine ganglion block for any indication.
11. Surgical interventions including occipital nerve decompression.
12. Pulsed RFA for the treatment of occipital neuralgia.

Current medical literature shows insufficient evidence to determine these services are standard medical treatments.

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